SECTION 3, Part B: Prevention for Individuals at Very High Risk for HIV Infection

PROCEDURAL GUIDANCE FOR IMPLEMENTATION OF PREVENTION CASE MANAGEMENT (PCM) FOR UNINFECTED PERSONS AT VERY HIGH RISK FOR HIV

CBO PROGRAM ANNOUNCEMENT RFP 04064
DEPARTMENT OF HEALTH AND HUMAN SERVICES

DESCRIPTION OF PCM FOR UNINFECTED PERSONS AT VERY HIGH RISK FOR HIV

Prevention Case Management (PCM) is a client-centered HIV prevention activity with the fundamental goal of promoting the adoption and maintenance of HIV risk-reduction behaviors by clients with multiple, complex problems and risk-reduction needs.[1,2] PCM provides client-centered, multiple-session HIV risk-reduction counseling to help individuals initiate and maintain behavior change to prevent the acquisition of HIV while addressing competing needs which may make HIV prevention a lower priority. This HIV prevention activity addresses the relationship between HIV risk and other issues such as substance abuse, mental health, social and cultural factors, and physical health.

As a hybrid of HIV risk-reduction counseling and traditional case management for PLWH, PCM provides intensive, on-going, individualized prevention counseling, support, and service brokerage. Priority for PCM services should be given to persons at very high risk for HIV defined as someone who, within the past 6 months, has had unprotected sex with a person who is living with HIV, unprotected sex in exchange for money or sex, multiple (greater than 5) or anonymous unprotected sex or needle-sharing partners, or been diagnosed with a sexually transmitted disease. PCM services might include traditional risk reduction topics such as abstinence, decreasing the number of sexual/needle-sharing partners or increasing condom use, as well as other subjects including referral to needed medical and psychosocial services affecting risk behavior, such as mental health and substance abuse treatment services or diagnosis and treatment of sexually transmitted diseases.

CORE ELEMENTS, KEY CHARACTERISTICS AND PROCEDURES

Core Elements are those components that are critical features of an intervention's intent and design and that are thought to be responsible for its effectiveness and that consequently must be maintained without alteration to ensure program effectiveness. Core elements are derived from the behavioral theory upon which the intervention is based. They are essential to the implementation of the program and cannot be ignored, added to, or changed. PCM has 6 core elements which include:

1) PCM is a hybrid of HIV risk reduction counseling and traditional case management.

2) PCM is based on the premise that some people may not be able to prioritize HIV prevention when they face problems perceived to be more important and immediate.

3) HIV-negative persons, or those of unknown serostatus are eligible when they have a recent history (past 6 months) of unprotected sex with a person who is living with HIV, unprotected sex in exchange for money or sex, multiple (greater than 5) or anonymous unprotected sex or needle-sharing partners, or been diagnosed with a sexually transmitted disease.

4) Individuals who are committed to participating in ongoing risk reduction counseling should be targeted.

5) Organizations must hire case managers with the appropriate training and skills to complete the PCM activities within their job description.

6) Clear procedure and protocol manuals for the PCM program must be developed to ensure effective delivery of PCM services and minimum standards of care.

Key Characteristics are crucial activities and delivery methods for conducting an intervention, which may be tailored for different agencies and at-risk populations. These characteristics, however, can be adapted or tailored to meet the needs of the target population and ensure cultural appropriateness of the strategy. PCM has 8 key characteristics**:**

- Develop a client recruitment and engagement strategy.
- Screen and assessing clients to identify those who are at highest risk and are appropriate for PCM.
- Develop a written, client-centered prevention plan.
- Provide multiple HIV risk-reduction counseling sessions.
- Provide active coordination of services with follow-up.
- Monitor and reassess clients' needs, risks, and progress.
- Establish protocols to classify clients as "active," "inactive," or "discharged," and outlining the minimum active effort required to retain clients.
- Discharge clients from PCM upon attainment and maintenance of risk reduction goals.

Procedures describe the activities that make up the content of the intervention and provide direction to agencies or organizations regarding the conduct of the intervention. Procedures for PCM follow:

Upon the client's introduction to the PCM program, providers should assure that clients understand the reason for the referral, the role of the PCM program, and the role of the provider. Written, informed consent describing all relevant policies and procedures (including the confidential and voluntary nature of the service) and a commitment to participate in ongoing risk-reduction counseling should be obtained. Clients should be provided a copy of this consent, and the original should be maintained in an individual client record. Each client should have an

individual confidential file, and all records should be kept in a locked file cabinet with access limited to the prevention case manager and his/her immediate supervisor.

All clients must be screened for eligibility for services. Appropriate screening procedures should be developed to identify persons at highest risk for transmission or acquisition of HIV. Assessment should address HIV and STD transmission risks, substance use/abuse, and medical and psychosocial needs, and care should be taken to assure that the assessment is conducted in a culturally appropriate manner.

After completion of the assessment, the PCM provider and the client should collaborate on the development of a prevention plan which is then signed by the client and provider. The plan should outline and define risk-reduction behavioral objectives and strategies for behavioral change. In addition to risk reduction goals, the plan should include referral to appropriate medical care if needed. The plan must also included referral for evaluation and treatment of STDs, TB, hepatitis and other related health concerns at regular intervals, and should address referral for substance abuse treatment if necessary. Prevention plans for HIV-negative or unknown serostatus clients should include goals related to counseling and testing as necessary. Finally, plans for referral follow-up should be outlined.

When risk behaviors have been identified and appropriate risk-reduction strategies have been outlined, prevention case management sessions begin. Multiple counseling sessions are aimed at meeting the identified behavioral objectives. These sessions may include education, skill development, role-play, support, or other techniques. Client notes should be filed after each session indicating, at a minimum, the goal addressed during the session, progress toward the goal, barriers to implementation of behavior change and the way these are or will be addressed, referrals made with plans for follow-up, and a plan for the next session.

PCM providers should assure active coordination of services with follow-up to avoid duplication of services (for example, agency protocols should address co-managing clients with other case managers if appropriate). If referrals are to be made as a part of the prevention plan, the agency should have a standardized written referral process, and a system should be in place to ensure availability and access to these referrals and to track their completion. This system might include formal or informal agreements including memoranda of agreement with relevant service providers. Written informed consent from the client for sharing client information should be obtained before communication between agencies begins. Medical and psychological services should be available if emergencies arise, and referral agreements for these services should be in place before initiating PCM. Current referral and access information for all community providers should be maintained.

Ongoing needs assessment is essential to monitor progress toward PCM goals and to monitor changing needs of the client. Prevention plans must be updated to reflect any change. Upon attainment and maintenance of the objectives of the plan a determination should be made by the client and the PCM provider that the client is ready for discharge from PCM. Agencies implementing PCM must have discharge protocols in place to ensure that discharged clients are connected to needed services and resources, and a return to PCM is available if needed.

RESOURCE REQUIREMENTS

Because prevention case management is an intervention with a great deal of overlap with mental health services, providers must have experience in managing mental health issues (a licensed counseling or mental health provider is preferred). Staffing levels will vary according to the number of clients that an agency expects to serve and the availability of other services in the area in the service area. In areas with limited referral sources, the PCM provider will be expected to meet multiple needs for his/her clients thus reducing case load for individual providers. In resource-rich areas, more service needs can be met by referral and a PCM provider can therefore be expected to carry a larger caseload. Programs should consider the number of clients to be served, the needs of those clients and the services available in their area when determining staffing levels needed, but a typical caseload will include approximately 15 - 20 clients for each 1.0 FTE PCM provider.

RECRUITMENT

PCM programs rely upon referrals and recruitment to establish a client base. To enlist clients for PCM, programs should be located in a setting with other services for the targeted population. In this way, clients can be referred from existing services that the program offers including outreach, counseling and testing services, medical care, STD assessment and treatment, substance abuse treatment, or mental health services. If these services are not offered on site, referral agreements from agencies providing these services should be established. Incentives (for example, bus tokens, hygiene kits, t-shirts) can be used to increase participation.

Agencies wishing to implement PCM should review the Procedural Guidance for Recruitment in order to choose a recruitment strategy that will work in the setting in which they plan to implement PCM.

PHYSICAL SETTING CHARACTERISTICS

Agencies implementing PCM should choose a location that is easily accessible from public transportation routes. The intervention sessions must be conducted in a private and secure location so that confidentiality of participants can be maintained. It is crucial that intervention sessions are not interrupted by distractions such as people entering and exiting the room, or outside noise levels. It may be necessary for providers to meet clients outside of an office setting. In this case, efforts should be made to secure a location that will assure the confidentiality of the client and minimize distractions and interruptions. Regardless of where actual PCM sessions occur, the agency implementing the intervention must assure that all records are maintained in a locked file cabinet or in a secured computer workstation.

NECESSARY POLICIES AND STANDARDS

Before an agency attempts to implement PCM the following policies and procedures should be in place to protect participants, the agency, and the Prevention Case Manager:

Informed Consent: Agencies must have a consent form which carefully and clearly explains in accessible language the agency's responsibility and the participants' rights. Individual state laws apply to consent procedures for minors, but at a minimum consent should be obtained from each participant and/or a legal guardian if the participant is a minor or unable to give legal consent. Client participation must always be voluntary and documentation of this informed consent must be maintained in the client's record.

Legal/Ethical Policies: Agencies must know their state laws regarding disclosure of HIV status to sexual and/or needle-sharing partners, and agencies are obligated to inform participants of the potential duty warn and the agency's responsibility if a PCM client tests positive for HIV. Agencies also must inform participants about state laws regarding the reporting of domestic violence, child abuse, sexual abuse of minors, and elder abuse.

Confidentiality: A system must be in place to ensure that confidentiality is maintained for all participants in the program. Before sharing any information with another agency to which a client is referred, signed informed consent from a client or his/her legal guardian must be obtained.

Data Security: Collect and report data consistent with CDC requirements to ensure data security and client confidentiality.

Cultural Competence: Agencies must strive to offer culturally competent service by being aware of the demographic, cultural, and epidemiological profile of their communities. Agencies should hire, promote, and train staff across all disciplines to be representative of and sensitive to these cultures. In addition, materials and services must be offered in the preferred language of clients/consumers where possible, or translation should be available if appropriate. Finally, agencies should facilitate community and client/consumer involvement in designing and implementing prevention services to ensure that important cultural issues are incorporated. The Office of Minority Health of the Department of Health and Human Services has published the *National Standards for Culturally and Linguistically Appropriate Services in Health Care* which should be used as a guide for ensuring cultural competency in programs and services. Please see the Cultural Competence section in the introduction of this document (page 9) for standards for developing culturally and linguistically competent programs and services.

Referrals: Agencies must be prepared to supply appropriate referrals to session participants as necessary. Providers must know about referral sources for prevention interventions/counseling (Partner Counseling and Referral Services, or other Health Department/Community Based Organization prevention programs) if consumers need additional assistance in decreasing risk behavior. All persons screened for PCM, regardless of eligibility, should be offered counseling by a prevention case manager and referrals relevant to their needs.

Volunteers: If the agency is using volunteers to assist in or conduct this intervention, then the agency should know and disclose how their liability insurance and worker's compensation applies to volunteers. Agencies must ensure that volunteers also receive the same training and are held to the same performance standards as employees. Agencies must also ensure that volunteers sign and adhere to a confidentiality statement. All training should be documented.

QUALITY ASSURANCE

Quality assurance activities for both providers and participants should be in place when implementing PCM:

Provider: Providers of PCM services should be have experience working in the fields of mental health services and HIV prevention (a licensed counseling or mental health provider is preferred). Agencies should have in place a mechanism to assure that all sessions address the prevention plan. QA activities can include observation and review of sessions by key staff and supervisors involved with the activity. This review should focus on the quality of and appropriate adherence to the prevention plan, accessibility and responsiveness to expressed client needs; and important process elements (e.g., time allocation, clarity). PCM providers should meet at least monthly with either a direct supervisor or with a peer supervisor. Selected intervention record reviews should focus on assuring that consent forms (signed either by the participant if he/she is over 18 or emancipated, or by a legal guardian) are included for all participants, and session notes are of sufficient detail to assure that clients are participating actively.

Participant: Participants' satisfaction with the intervention and their comfort should be assessed at regular intervals of the agency's choosing.

MONITORING AND EVALUATION

Evaluation and monitoring of recruitment activities include the following:

- Collect and report client-level data.
- Collect and report standardized process and outcome monitoring data consistent with CDC requirements.
- Use of the CDC developed PEMS (Program Evaluation Monitoring System) to report date electronically. Organizations may use, under certain circumstances, a local system provided it meets required system specifications.
- Collect and report data consistent with CDC's requirements to ensure data quality and security and client confidentiality.
- Collaborate with CDC in assessing the impact of HIV prevention activities by participating in special projects upon request.
- Collect and report data on the following indicators:
    - **I.C-** Proportion of persons that completed the intended number of sessions for each of the following interventions: individual level interventions (ILI) and group level interventions (GLI).

- **III.B-** Proportion of persons at very high risk for HIV infection that completed the intended number of sessions for each of the prevention interventions supported by this program announcement.
- **IV.A-** Proportion of client records with the CDC-required demographic and behavioral risk information

KEY ARTICLES AND RESOURCES

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UCSF, AIDS Policy Research Center, Prevention with Positives Resources

PROCEDURAL GUIDANCE FOR IMPLEMENTATION OF VOICES/VOCES

CBO PROGRAM ANNOUNCEMENT RFP 04064
DEPARTMENT OF HEALTH AND HUMAN SERVICES

DESCRIPTION OF VOICES/VOCES

Video Opportunities for Innovative Condom Education and Safer Sex (VOICES/VOCES) is a single-session, video-based HIV/STD prevention workshop designed to encourage condom use and improve condom negotiation skills among African-American and Latino men and women.[1] The original research was conducted in STD clinics; however, the intervention has also been used in family planning centers, community health centers, drug rehabilitation clinics, correctional facilities and other settings. VOICES/VOCES is a brief bilingual English and Spanish) HIV prevention intervention that is designed to be easily integrated into the flow of services provided by busy community-based agencies. It fits effective prevention education into the time frame of a clinic visit or other brief opportunity to reach clients during a "teachable moment." VOICES/VOCES targets people who are at very high risk for HIV/STDs. This intervention has been packaged by CDC's Diffusion of Effective Behavioral Interventions (DEBI) project and information on obtaining the intervention training and materials is available at www.effectiveinterventions.org.

To implement the VOICES/VOCES intervention, health educators convene groups of four to eight clients in a room that allows privacy for discussion. Whenever possible, groups are gender- and ethnic-specific, so that participants can develop prevention strategies appropriate for their culture. Information on HIV risk behaviors and condom use is delivered using videos, facilitated group discussion, and a board presenting features of various condom brands in English and Spanish. Two culturally-specific videos are used: one for African-American participants and a bilingual video for Latinos. Skills in condom use and negotiation are modeled in the videos, then role-played and practiced by participants during the discussion that follows. At the end of the single, 45-minute session, participants are given samples of the types of condoms they have identified as best meeting their needs.

VOICES/VOCES is one-time 45 minute intervention that produced significant results in field trials, demonstrating both biological markers and self-reported behavior change. Participants in VOICES/VOCES had a significantly lower rate of new STD infection than participants in the comparison condition. In addition, participants had increased knowledge of the transmission of HIV and other STDs as well as intentions to use condoms regularly. They were also more likely to go get more condoms at a neighborhood store in the weeks after their clinic visit.[1]

CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES

Core Elements are those components that are critical features of an intervention or strategy's intent and design and that are thought to be responsible for its effectiveness. Consequently, they must be maintained without alteration to ensure program effectiveness. Core elements are derived from the behavioral theory upon which it the intervention or strategy is based. They are essential to the implementation of the program and cannot be ignored, added to, or changed. of VOICES/VOCES has 4 core elements:

1) Viewing culturally-specific videos portraying condom negotiation.

2) Convening small group skill-building sessions to work on overcoming barriers to condom use.

3) Educating program participants about different types of condoms and their features.

4) Distributing samples of condoms identified by participants as best meeting their needs.

Key Characteristics are crucial activities and delivery methods for conducting an intervention, which may be tailored for different agencies and at-risk populations to meet the needs of the target population and ensure cultural appropriateness of the strategy. Key characteristics of VOCES/VOCES are:

- Introducing VOICES/VOCES as a routine part of clinic/agency services
- Convening 4 to 8 persons of the same gender and race/ethnicity to allow for open discussion of sensitive issues among persons holding similar cultural values
- Conducting the intervention session in a private space
- Delivering the intervention in a single 40- to 60-minute session
- Viewing a 15- to 20-minute culturally-specific video as the intervention's starting point
- Showing a brief video that:
  - reflects up-to-date information on HIV/STDs
  - uses male and female actors with racial and ethnic backgrounds similar to the persons viewing the video
  - depicts real-life situations involving characters like the clients themselves
  - shows condom negotiation as a shared responsibility between sex partners
  - models communication skills & HIV/STD prevention attitudes and behaviors
  - includes subject matter that is explicit, but appropriate for viewing at your site
- Using the characters and situations depicted in the video to launch group discussion
- Addressing barriers to condom use and safer sex by
  - increasing awareness of personal risk for HIV/STD infection
  - providing information on safer sex to prevent infection
  - correcting misinformation about condom use
  - presenting the features of different types of condoms to address objections to using condoms

  - having clients practice correct condom use and condom negotiation to enhance their self-efficacy
- Providing three condoms to each client of the type they identified as best meeting their needs

Procedures describe the activities that make up the content of the intervention and provide direction to agencies or organizations regarding the conduct of the intervention. Procedures for implementing VOICES/VOCES follow:

Viewing of Culturally Specific Video

Videos quickly transmit necessary information and model attitudes and behaviors regarding safer sex appropriate to members of particular cultures. In VOICES/VOCES, videos provide a non-threatening starting point for groups of strangers, brought together for one brief session, to discuss intimate topics and behaviors. Videos also provide a safe context for discussing culturally-sensitive issues. This context is especially important when the race/ethnicity or other characteristics of group facilitators are not the same as group participants—as is often the case with community health agencies providing services to diverse client populations.

Two videos have been developed for the VOICES/VOCES intervention: *Porque Sí* and *Love Exchange*. Each is tailored to the needs of its particular target population. *Porque Sí*, a bilingual Spanish and English video, is designed to be used with Latino men and women. *Love Exchange* is directed toward African-Americans.

Other videos may be substituted or included in the intervention as long as they meet the criteria outlined in the VOICES/VOCES Implementation Manual.

Small-Group Skill-Building Sessions

The interactive sessions that follow video viewing are the heart of the VOICES/VOCES intervention. These sessions help clients develop and practice the skills they need to negotiate condom use. They provide an opportunity for participants to discuss problems they have encountered in trying to adopt safer sex behaviors, and, with peers, develop and practice strategies for overcoming these problems. Facilitators lead groups made up of four to eight clients, using a standardized protocol to guide discussion. Facilitators begin by asking participants specific questions about the characters and events depicted in the video. Facilitators then encourage participants to relate these situations to their own lives. Sessions address barriers to condom use and safer sex by providing information, correcting misinformation, discussing condom options, and having clients practice condom-negotiation techniques. Sessions follow a consistent format, but the content is tailored to address the concerns and experiences of each group of participants. If possible, groups should include members of the same gender; that is, they should be men only or women only, to allow for open discussion of sensitive issues surrounding sexual behaviors and attitudes.

Condom Feature Education

The condom education component of the intervention supplements the skill-building session by providing clients with detailed information about condoms and how to choose a condom that they and their partner will feel most comfortable using. This component offers aids to familiarize clients with condoms and their features, making it easier for them to obtain and correctly use condoms. The bilingual Condom Features Poster Board, available in the intervention kit, is used for this activity.

Distribution of Sample Condoms

At the end of the VOICES/VOCES session, participants are given samples of the types of condoms they have identified as best meeting their needs.

RESOURCE REQUIREMENTS

In most situations, current agency staff can easily learn to implement VOICES/VOCES. Key to the success of VOICES/VOCES is 1-2 staff who facilitate or implement the intervention and an agency manager who will oversee and support implementation. Staff facilitators should have the skills to identify and recruit clients to participate in a small-group intervention, to show the video, and to conduct the small-group skill-building sessions. Current staff members may be qualified to undertake this new responsibility. Having more than one staff facilitator helps assure that continuity of the program and consistency in the case of absences or turnover. Facilitators also can provide one another support and help trouble shoot any issues that arise.

Also critical to the adoption and success of the intervention is the manager who is willing to act as an intervention "champion." In this role, the manager oversees maintenance, quality control, and documentation. The manager introduces the intervention, supports it through implementation, and sees that it becomes a regular part of services. The manager can also help secure resources, work in partnership with local and state public health agencies, identify and address potential problems, answer questions, and, in general, serve as an advocate for improved prevention services.

There are recommendations for staff preparation for adopting and implementing VOICES/VOCES. Managers who provide guidance and leadership on the VOICES/VOCES intervention must attend a half-day orientation to the intervention, its objectives, and resource needs. Staff facilitators who will be convening and conducting group sessions also attend this half-day training with managers as well as a one and a half day training on how to conduct the intervention, practice group facilitation skills, and identify agency-specific implementation strategies.

To implement VOICES/VOCES start-up costs can include purchase of video equipment as well as the costs of staff training and orientation. Some of the costs associated with intervention maintenance can include such categories as ongoing personnel costs for running the VOICES/VOCES group sessions (including both facilitator and supervisor time), the rental/space costs of the room required for holding groups, materials (such as condoms) replacement, and ongoing technical assistance. Because VOICES/VOCES is primarily intended to be fit into the opportunity provided by a client's routine visit to an STD clinic or similar health

service or community agency, additional costs incurred by participants are often negligible, since little additional travel or time investment is required.[2]

RECRUITMENT

Implementing VOICES/VOCES involves recruiting clients from your agency to participate in same-gender, same-ethnic small groups. Make VOICES/VOCES a part of routine services, and offer it on a regular basis to as many clients who may benefit as possible every week. Successful recruitment involves determining where VOICES/VOCES fits into the flow of your agency services. Agency staff can recruit clients who are at very high risk for HIV and other STDs and enroll them into group sessions presenting the intervention as part of the client's regular clinic visit. General recruitment into the VOICES/VOCES sessions can include word of mouth, and other marketing strategies including flyers, newsletters, and special events. Peer-to-peer recruitment strategies can also be effective ways to bring clients into the small groups

PHYSICAL SETTING CHARACTERISTICS

VOICES/VOCES was shown to be effective when delivered at a "teachable moment," for example, when a visit to an STD clinic may motivate a person to change behavior. However, many clients at very high risk for developing and transmitting HIV and other STDs are no longer treated in STD clinics, yet might benefit greatly from the VOICES/VOCES intervention. New users should examine their own clinic and agency settings and develop strategies for delivering the intervention so the greatest number of clients will benefit. Apart from STD clinics, recommended venues for implementation include family planning clinics, community health centers, community-based organizations, drug rehabilitation centers and correctional facilities. The main requirement of the physical setting include a private room, a television and a VCR.

NECESSARY POLICIES AND STANDARDS

Before an agency attempts to implement VOICES/VOCES, the following policies and procedures should be in place to protect participants, and the agency:

Informed Consent: Agencies must have a consent form which carefully and clearly explains in accessible language the agency's responsibility and the participants' rights. Individual state laws apply to consent procedures for minors, but at a minimum consent should be obtained from each participant and/or a legal guardian if the participant is a minor or unable to give legal consent. Client participation must always be voluntary and documentation of this informed consent must be maintained in the client's record.

Legal/Ethical Policies: Agencies must know their state laws regarding disclosure of HIV status to sexual and/or needle-sharing partners, and agencies are obligated to inform participants of the potential duty warn and the agency's responsibility if a client tests positive for HIV. Agencies also must inform participants about state laws regarding the reporting of domestic violence, child abuse, sexual abuse of minors, and elder abuse.

Confidentiality: A system must be in place to ensure that confidentiality is maintained for all participants in the program. Before sharing any information with another agency to which a client is referred, signed informed consent from a client or his/her legal guardian must be obtained.

Data Security: Collect and report data consistent with CDC requirements to ensure data security and client confidentiality.

Cultural Competence: Agencies must strive to offer culturally competent service by being aware of the demographic, cultural, and epidemiological profile of their communities. Agencies should hire, promote, and train staff across all disciplines to be representative of and sensitive to these cultures. In addition, materials and services must be offered in the preferred language of clients/consumers where possible, or translation should be available if appropriate. Finally, agencies should facilitate community and client/consumer involvement in designing and implementing prevention services to ensure that important cultural issues are incorporated. The Office of Minority Health of the Department of Health and Human Services has published the *National Standards for Culturally and Linguistically Appropriate Services in Health Care* which should be used as a guide for ensuring cultural competency in programs and services. Please see the Cultural Competence section in the introduction of this document (page 9) for standards for developing culturally and linguistically competent programs and services.

Referrals: Agencies must be prepared to supply appropriate referrals to session participants as necessary. Providers must know about referral sources for prevention interventions/counseling (Partner Counseling and Referral Services, or other Health Department/Community Based Organization prevention programs) if clients need additional assistance in decreasing risk behavior.

Volunteers: If the agency is using volunteers to assist in or conduct this intervention, then the agency should know and disclose how their liability insurance and worker's compensation applies to volunteers. Agencies must ensure that volunteers also receive the same training and are held to the same performance standards as employees. Agencies must also ensure that volunteers sign and adhere to a confidentiality statement. All training should be documented.

QUALITY ASSURANCE

Quality assurance for this intervention requires the agency manager/administrator to provide hands-on leadership and guidance for the intervention—from preparation through institutionalization. By attending the orientation session along with agency facilitators, the agency manager/administrator is prepared to provide this guidance.

The VOICES/VOCES implementation manual provides quality assurance and process monitoring and process evaluation procedures and describes the experience of others who have used the intervention. The implementation manual also guides staff on how to incorporate feedback and findings from quality assurance and process evaluations into VOICES/VOCES programming.

Throughout implementation, it is necessary to determine whether staff is delivering VOICES/VOCES with fidelity to the four core elements. It is also necessary to identify any issues that should be addressed to assure the intervention is meeting the needs of agency clients and staff. Staff implementing VOICES/VOCES will use the "Quality Assurance Checklist" contained in the Implementation Manual. This checklist helps staff to identify, discuss and solve problems in successfully implementing the intervention.

Staff will implement the Client Satisfaction Survey contained in the Implementation Manual or their own satisfaction survey to collect feedback from clients participating in the VOICES/VOCES intervention. Feedback will be used from the results of the survey to strengthen the implementation of the intervention.

MONITORING AND EVALUATION

Evaluation and monitoring intervention activities include the following:

- Collect and report standardized process and outcome monitoring data consistent with CDC requirements;
- Enter and transmit data for CDC-funded services on PEMS (Program Evaluation Monitoring System), a CDC-provided browser-based system, or describe plans to make a local system compatible with CDC's requirements;
- Collect and report data consistent with the CDC requirements to ensure data quality and security and client confidentiality;
- Collaborate with CDC in assessing the impact of HIV prevention activities by participating in special projects upon request.
- Collect and report data on the following indicators:
    - **I.C-** Proportion of persons that completed the intended number of sessions for each of the following interventions: individual level interventions (ILI) and group level interventions (GLI).
    - **III.B-** Proportion of persons at very high risk for HIV infection that completed the intended number of sessions for each of the prevention interventions supported by this program announcement.
    - **IV.A-** Proportion of client records with the CDC-required demographic and behavioral risk information

KEY ARTICLES AND RESOURCES

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O'Donnell L, San Doval A, Vornfett R, O'Donnell C. STD prevention and the challenge of gender and cultural diversity: Knowledge, attitudes, and risk behaviors among black and Hispanic inner-city STD clinic patients. Sexually Transmitted Diseases, 1994:21 (3):137-148.

For more information on the VOICES/VOICES intervention, training and technical assistance or to get your name on a list for a future training, please go the website: www.effectiveinterventions.org.

PROCEDURAL GUIDANCE FOR IMPLEMENTATION OF THE SISTA PROJECT— A PEER LED PROGRAM TO PREVENT HIV INFECTION AMONG AFRICAN AMERICAN WOMEN

CBO PROGRAM ANNOUNCEMENT RFP 04064
DEPARTMENT OF HEALTH AND HUMAN SERVICES

DESCRIPTION OF SISTA

The SISTA Project—or **S**isters **I**nforming **S**isters **A**bout **T**opics on **A**IDS -- is a social skills training intervention aimed at reducing HIV sexual risk behavior among African American women at highest risk.[1-3] It is composed of five two-hour sessions delivered by peer facilitators in a community based setting. The sessions are gender – and culturally- relevant and include behavioral skills practice, group discussions, lectures, role play, a prevention video, and take home exercises. The five sessions that generate these discussions and activities include Ethnic/Gender Pride; HIV/AIDS Education; Self Assertiveness Skills Training; Behavioral Skills Management; and Coping. This intervention has been packaged by CDC's Diffusion of Effective Behavioral Interventions (DEBI) project and information on obtaining the intervention training and materials is available at www.effectiveinterventions.org.

SISTA applies both the Social Cognitive Theory and the theory of gender and power. According to the Social Cognitive Theory, people need information (HIV risk-information), training in social and behavioral skills, and knowledge of norms to apply risk-reduction strategies. A change in behavior is dependent upon self-efficacy, self confidence, and outcome expectations.

The theory of gender and power is a social structural theory that accounts for gender-based power differences in male-female relationships. It examines, by gender, the division of labor and the distribution of power and authority within relationships and gender-based definitions of sexually appropriate conduct. In addition, the theory considers the impact of a woman's willingness to adopt and maintain sexual risk-reduction strategies within heterosexual relationships as it pertains to her lack of power, her commitment to the relationship and her role in the relationship.

The study was originally implemented with 128 heterosexual women. Results indicated that a social skills training that is delivered in a community setting can positively affect condom use. Specifically, women in the experimental condition reported more condom use than women in the control condition.[1]

CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES

Core Elements are those components that are critical features of an intervention's or strategy's intent and design that are thought to be responsible for its effectiveness. Consequently, they must be maintained without alteration to ensure program effectiveness. Core elements are derived from the behavioral theory upon which the intervention or strategy is based. They are essential to the implementation of the program and cannot be ignored, added to, or changed. SISTA has 7 core elements which include:

1) Small group sessions to discuss the session objectives, address the challenges and joys of being an African American woman, model skills development and role play women's skills acquisition.

2) Use of a skilled facilitator to implement the group sessions because the success of the SISTA Program depends on the skill of the facilitator.

3) Use of cultural and gender appropriate materials to acknowledge pride, enhance self worth in being an African American woman (e.g., use of poetry, artwork by African American women).

4) Training of women in sexual assertion skills so that they can both demonstrate care for partners and negotiate safe behaviors.

5) Teaching women proper condom use skills. SISTA is designed to foster positive attitudes and norms towards consistent condom use and provide women the appropriate instruction for placing condoms on their partner.

6) Discussions of the cultural and gender triggers that may make it challenging to negotiate safer sex.

7) Emphasis on the importance of the partner's involvement in safer sex. The homework activities that are included in the SISTA Project are designed to involve the male partner.

Key Characteristics are crucial activities and delivery methods for conducting an intervention, which may be adapted or tailored to meet the needs of the target population in different agencies and ensure cultural appropriateness of the strategy. SISTA has the following key characteristics:

- Flexibility to be tailored for different populations of African American women, for example, women in substance abuse treatment facilities, incarcerated women, women residing in shelters, and sex workers.
- Passion, such that the facilitators can deliver the intervention with conviction and purpose.
- Cultural competency, in that it was developed by African American women and for African American women.

- Broad content that includes discussions not only about HIV prevention, but also about relationships, dating, and sexual health.

Procedures describe the activities that make up the content of the intervention and provide direction to agencies or organizations regarding the implementation of the intervention. Procedures for implementing the SISTA project follow.

The SISTA Project consists of:

- Five once-a-week sessions that are two hours each
- Two booster sessions administered two and four months after the project is completed, also two hours in length. These booster sessions are designed to provide an opportunity for the program participants to ask further questions and/or provide peer support
- A graduation party and a Certificate of Accomplishment for each of the participants after completion of the second booster session

Each of the sessions has a specific goal and objectives. The goals and activities of each of the sessions follow:

Session 1-Ethnic/Gender Pride:

Goal: Generate a discussion about being African-American and female, having pride in oneself, and valuing oneself.

During the first session, the facilitators will:

- Distribute an opening poem that will be read with and/or to the women
- Introduce themselves to the women, introduce the intervention to the women and introduce the women to each other
- Encourage the women to develop ground rules and expectations
- Facilitate a discussion about the positive qualities of black women and how they can be used as a source of strength and pride; conduct a discussion on values, requesting the women to prioritize their personal values
- Encourage the women to complete a simple homework exercise
- Distribute anonymous evaluation forms to assess the first session
- Read a closing poem with and/or to the women and recite the SISTA motto with the women

Session 2-HIV/AIDS Education:

Goal: Provide factual and statistical information on HIV/AIDS and other sexually transmitted diseases (STDs), correct misconceptions about HIV/AIDS, and discuss the importance of protecting oneself.

During session 2, the facilitators will:

- Distribute a copy of a poem that will be read with and/or to the women
- Review ground rules and expectations
- Review the key concepts of session 1 and discuss the homework exercise from day 1
- Distribute information and handouts on HIV/AIDS and initiate discussions about the information
- Engage the women in a Card Swap game to demonstrate how people get HIV and spread it to other people
- Present a 30 minute video and discuss
- Distribute homework assignments
- Distribute anonymous evaluation forms to assess the second session
- Recite the SISTA motto with the women.

Session 3-Assertiveness Skills Training:

Goal: Teach the distinction among assertive, aggressive and non-assertive behaviors and teach skills to initiate assertive qualities.

During the third session, the facilitator will:

- Distribute a copy of a poem that will be read with and/or to the women
- Review the key concepts of session 2 and discuss the homework exercise from day 2
- Facilitate a discussion on the difference between assertion and aggression
- Distribute a handout on various realistic situations and ask the women to provide examples and consequences of assertive, aggressive and non- assertive responses to the situations; discuss steps in the decision making process
- Distribute homework assignments will be distributed
- Distribute anonymous evaluation forms to assess the third session
- Read the closing poem with and/or to the women and recite the SISTA motto with the women

Session 4-Behavioral Self-Management:

Goal: Decrease participants' anxiety about condom use, demonstrate and role-play how to use condoms and discuss reasons that women do not insist upon using condoms.

During session 4, the facilitator will:

- Distribute a copy of a poem that will be read with and/or to the women
- Review the key concepts of session 3 and discuss the homework exercise from day 3
- Facilitate a discussion on why people do not use condoms and develop a strategy for overcoming these stated obstacles
- Distribute condom packets and lubricant
- Engage the women in a condom-card line-up activity to assess their knowledge of putting on a condom

- Demonstrate how to put on a condom
- Role play negotiation exercises
- Disseminate homework assignments
- Distribute anonymous evaluation forms
- Read the closing poem with and/or to the women and recite the SISTA motto with the women

Session 5-Coping Skills:

Goal: Initiate discussion about coping with life experiences -- including the link between alcohol and AIDS, coping with alcohol and sex, and coping with negative responses. This session also serves as a review of the previous sessions.

During the fifth session, the facilitator will:

- Distribute a copy of a poem that will be read with and/or to the women
- Review the key concepts of session 4 and discuss the homework exercise from day 4
- Review the handouts from previous sessions
- Discuss what coping is and its relationship to alcohol
- Distribute a handout on coping situations
- Inform the group of the booster sessions
- Distribute Anonymous Evaluation forms
- Read the closing poem with and/or to the women and recite the SISTA motto with the women

Booster Sessions: The booster sessions offer participants the opportunity to ask questions, stimulate thinking/knowledge of lessons learned, and reinforce the importance of protecting oneself. The first booster session is held two months after the last session of the intervention. The facilitator will facilitate discussions on (1) how the intervention could be strengthened; (2) whether the participants are using their newly developed skills; and, (3) any challenges that the participants have encountered. In addition, participants will begin designing their graduation ceremony.

The second booster session is held four months after the intervention. Additional questions are answered and the graduation ceremony is held.

RESOURCE REQUIREMENTS

The SISTA intervention should be facilitated by two peer health educators (at least one full time employee). Peers should be of the same race/ethnicity and gender as the target population. The staff should be well versed on HIV transmission and methods for preventing HIV transmission and should have a non-judgmental attitude toward people living with HIV/AIDS. Partnering agencies, if any, should be identified as well as a location to conduct a group session with 10-12 women.

Prior to implementing the intervention the staff should thoroughly review all program materials, plans, and logistics. Specific materials and instructions are provided in the intervention kit. In addition, the staff should copy materials, purchase incentives (described below) and other materials necessary to implement the intervention. Staff should create a culturally sensitive atmosphere and should understand the participant's cultural heritage and institutional barriers. Staff-participant language and dialect matches should also be considered. This will enable the staff to understand how the clients relate to the world.

RECRUITMENT

To encourage participation, SISTA should be publicized as a program for African-American women developed by African-American women that discusses dating, relationships, healthy sexual practices, and works at improving women's ability to effectively communicate with sexual partners. SISTA is a behavioral change intervention targeting women at very high risk for HIV. Clients may be recruited from various venues, including shelters, juvenile court systems, bars, focus groups, jails/prisons, STD clinics or community organizations. Specific cultural needs should be addressed when finding a client population.

Agencies implementing SISTA should see the Procedural Guidance for Recruitment in this document for recruitment strategy options.

Incentives can be used to effectively enhance retention in the SISTA program. For example, bus tokens may be used to provide women with transportation to and from the sessions, childcare may be provided during the sessions. In addition, gift certificates, monetary incentives, and food are all used as positive reinforcements.

PHYSICAL SETTING AND CHARACTERISTICS

Agencies implementing SISTA should choose a location that is easily accessible from public transportation routes. The intervention sessions must be conducted in a secure location such that confidentiality of participants is maintained. It is important that sessions are not interrupted by distractions, such as people entering and exiting the room, or outside noise levels. The location should be able to accommodate 10-12 persons comfortably and privately. In addition, the agency should take into consideration the intervention activities, including role play and role demonstration.

NECESSARY POLICIES AND STANDARDS

Before an agency attempts to implement POL the following policies and procedures should be in place to protect clients, the agency, and the facilitators:

Targeting of Services: Agencies must establish criteria for, and justify the selection of, the target populations. Selection of target populations must be based on epidemiological data,

behavioral and clinical surveillance, and the state or local HIV prevention plan created with input from the state or local community planning group(s).

Informed Consent: Agencies must have a consent form which carefully and clearly explains in accessible language the agency's responsibility and the participants' rights. Individual state laws apply to consent procedures for minors, but at a minimum consent should be obtained from each participant and/or a legal guardian if the participant is a minor or unable to give legal consent. Client participation must always be voluntary and documentation of this informed consent must be maintained in the client's record.

Safety: Agency policies must exist for maintaining safety of workers and clients. Plans for dealing with medical or psychological emergencies must be documented.

Confidentiality: A system must be in place to ensure that confidentiality is maintained for all participants in the program. Before sharing any information with another agency to which a client is referred, signed informed consent from a client or his/her legal guardian must be obtained.

Legal/Ethical Policies: Agencies must know their state laws regarding disclosure of HIV status to sexual and/or needle-sharing partners, and agencies are obligated to inform participants of the potential duty warn and the agency's responsibility if a client tests positive for HIV. Agencies also must inform participants about state laws regarding the reporting of domestic violence, child abuse, sexual abuse of minors, and elder abuse.

Linkage of Services: Recruitment and health education and risk reduction must be linked to counseling, testing, and referral services for clients of unknown status, and to care and prevention services for people living with HIV (PLWH). Agencies must develop ways to assess whether and how frequently the referrals made by staff were completed.

Referrals: Agencies must be prepared to supply appropriate referrals to session participants as necessary. Providers must know about referral sources for prevention interventions/counseling (Partner Counseling and Referral Services, or other Health Department/Community Based Organization prevention programs) if clients need additional assistance in decreasing risk behavior.

Data Security: Collect and report data consistent with CDC requirements to ensure data security and client confidentiality.

Cultural Competence: Agencies must strive to offer culturally competent service by being aware of the demographic, cultural, and epidemiological profile of their communities. Agencies should hire, promote, and train staff across all disciplines to be representative of and sensitive to these cultures. In addition, materials and services must be offered in the preferred language of clients/consumers where possible, or translation should be available if appropriate. Agencies should facilitate community and client/consumer involvement in designing and implementing prevention services to ensure that important cultural issues are incorporated. The Office of Minority Health of the Department of Health and Human Services has published the *National*

Standards for Culturally and Linguistically Appropriate Services in Health Care which should be used as a guide for ensuring cultural competency in programs and services. Please see the Cultural Competence section in the introduction of this document (page 9) for standards for developing culturally and linguistically competent programs and services.

Personnel Policies: Agencies conducting recruitment, outreach, and health education and risk reduction, must established a code of conduct. This code should include, but not be limited to, no drug or alcohol use, appropriate behavior with clients, and no loaning or borrowing of money.

Volunteers: If the agency is using volunteers to assist in or conduct this intervention, then the agency should know and disclose how their liability insurance and worker's compensation applies to volunteers. Agencies must ensure that volunteers also receive the same training and are held to the same performance standards as employees. Agencies must also ensure that volunteers sign and adhere to a confidentiality statement. All training should be documented.

QUALITY ASSURANCE

Quality assurance (QA) activities for both providers and participants should be in place when implementing SISTA.

Provider: Facilitators of SISTA should have extensive knowledge of HIV transmission and statistics in their local jurisdictions as well as national statistics. Facilitators should reflect the target population in race and gender and will be expected to deliver the information in a non-threatening and culturally relevant manner. Agencies should have in place a mechanism to ensure all sessions and core elements, as described above, are implemented. QA activities can include direct observation and review of sessions by staff involved in the intervention. The review could focus on the quality (or adherence to the fidelity) of the sessions delivered, and the responsiveness and openness of the women to the facilitator. Facilitators should collect all evaluation forms following each session and ensure participant confidentiality. In addition, facilitators should ensure that all participants are actively participating in each of the sessions. Bi-monthly meetings with supervisors to discuss progress and/or opportunities for change are encouraged.

Participants: The participants' satisfaction with the intervention and their comfort should be assessed during each session. Evaluation forms are provided in the intervention box and should be disseminated during each session. In addition, agencies can develop their own forms to assess participant satisfaction.

MONITORING AND EVALUATION

Evaluation and monitoring intervention activities include the following:

- Collect and report standardized process and outcome monitoring data consistent with CDC requirements;
- Enter and transmit data for CDC-funded services on PEMS (Program Evaluation Monitoring System), a CDC-provided browser-based system, or describe plans to make a local system compatible with CDC's requirements;
- Collect and report data consistent with the CDC requirements to ensure data quality and security and client confidentiality;
- Collaborate with CDC in assessing the impact of HIV prevention activities by participating in special projects upon request.
- Collect and report data on the following indicators:
    - **I.A-** The mean number of outreach contacts required to get one person with unknown or negative serostatus to access counseling and testing.
    - **I.B-** The proportion of person who access counseling and testing from each of the following interventions: individual level interventions and group level interventions.
    - **I.C-** Proportion of persons that completed the intended number of sessions for each of the following interventions: individual level interventions (ILI) and group level interventions (GLI).
    - **III.B-** Proportion of persons at very high risk for HIV infection that completed the intended number of sessions for each of the prevention interventions supported by this program announcement.
    - **IV.A-** Proportion of client records with the CDC-required demographic and behavioral risk information.
    - **V.A -** The mean number of outreach contacts required to get a person (living with HIV, their sex partners and injection drug-using contacts or at very high risk for HIV infection) to access referrals made under this program announcement.

KEY ARTICLES AND RESOURCES

[1]DiClemente RJ, Wingood GM. A Randomized controlled trial of an HIV sexual risk reduction intervention for young African American women. The Journal of the American Medical Association, 1995, 274(16), 1271-1276.

[2]Wingood GJ, DiClemente RJ. Partner influences and gender-related factors associated with noncondom use among young adult African American women. American Journal of Community Psychology, 1998, 26(1), 29-49.

[3]Wingood GM, DiClemente RJ. Application of the theory of gender and power to examine HIV-related exposures, risk factors, and effective interventions for women. Health Education & Behavior, 2000, 27(5), pages 539-565.

The SISTA Project intervention box was developed by Sociometrics. For more information on receiving training on this intervention, please visit www.effectiveinterventions.org.

PROCEDURAL GUIDANCE FOR IMPLEMENTATION OF STREET SMART

CBO PROGRAM ANNOUNCEMENT RFP 04064
DEPARTMENT OF HEALTH AND HUMAN SERVICES

DESCRIPTION OF STREET SMART

Street Smart is an intensive HIV/AIDS and STD prevention program for youth whose behaviors place them at very high risk of becoming infected.[1,2] Life circumstances define risk for some youth; being gay, runaway or homeless, or a sex offender increases the potential for risky behavior. Street Smart is designed for runaway and homeless youth, yet it can be easily adapted for very high risk youth in other settings. This intervention has been packaged by CDC's Diffusion of Effective Behavioral Interventions (DEBI) project and information on obtaining the intervention training and materials is available at www.effectiveinterventions.org.

The Street Smart program is the product of extensive collaboration among researchers, staff from public and private agencies serving homeless and runaway youth, and youth from diverse backgrounds. Staff and youth from homeless youth shelters and drop-in centers were instrumental in identifying key strategies to plan, implement, and evaluation the intervention.

Street Smart draws on social learning theory that describes the relationship between behavior change and a person's beliefs in his/her ability to change a behavior and that changing that behavior will produce a specific result. Street Smart links thoughts, feelings, and attitudes to behavior change. Beliefs about the consequences of behavior and perceptions for self-efficacy are key determinants of effective behavior change.

The Street Smart program is held in conjunction with existing services that attract youth, such as after dinner or before an art class. The intervention held over a two to six week period. The program consists of eight 1.5 to two-hour drop-in group sessions, one individual session, and a group visit to a community health resource. While it is preferable that teens attend every session, the program is designed so that each session stands on its own. Ideally six to ten youth attend the eight group sessions which are facilitated by two trained counselors. The intervention's goal is to reduce unprotected sex, number of sex partners, and substance use among runaway youth. The Street Smart program targets runaway youth, 11 – 18 years of age.

The sessions take place in small groups to provide support for a behavior change environment among the participants. A private session with a counselor is also included to allow each youth to personally identify and problem-solve their own barriers to safer sex and risk for HIV transmission. Additionally, participants can access medical care, mental health care, and referrals for specific individual health concerns if needed.

When Street Smart was implemented in research field trials, it was found that participants reported lower rates of substance use and unprotected sex acts following their participation in the

group sessions. Young women self-reported greater reductions in substance abuse and unprotected sex acts than young men; and African American youth self-reported less substance use than youth of other ethnic groups.[1,2]

CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES

Core Elements are those components that are critical features of an intervention or strategy's intent and design and that are thought to be responsible for its effectiveness. Consequently, they must be maintained without alteration to ensure program effectiveness. Core elements are derived from the behavioral theory upon which it the intervention or strategy is based. They are essential to the implementation of the program and cannot be ignored, added to, or changed. The Street Smart program has 4 core elements:

1) Increasing knowledge about HIV and its transmission including information about perinatal transmission, benefits of HIV testing and knowing one's status, stigma, and the emerging epidemiology of the epidemic.

2) Identifying personalized knowledge which consists of five basic components: outcome expectancies, peer and partners' social norms, self-efficacy, and perceived risk.

3) Acquisition of targeted skills in social assertiveness, condom use, problem-solving, self-talk, goal setting, and affect awareness and regulation.

4) Access to resources to effect positive change in their lives.

Key Characteristics are crucial activities and delivery methods for conducting an intervention, which may be tailored for different agencies and at-risk populations to meet the needs of the target population and ensure cultural appropriateness of the strategy. Key characteristics of Street Smart are:

- Convening groups of 6 to 10 adolescents of both sexes
- Delivering the intervention in eight, 90- to 120-minute sessions, one individual counseling session, and one trip to a community resource
- Conducting the intervention sessions in a large, comfortable room protected from interruptions
- Reinforcing positive behavior through frequent use of tokens and verbal appreciation
- Building group cohesion through participants sharing and giving appreciation to others for their contributions
- Eliciting participants' assessment of their feelings by using the "Feeling Thermometer" and labeling the feelings they are experiencing
- Using role-playing as an opportunity for participants to practice and observe typical circumstances in an instructive and supportive environment
- Videotaping exercises so participants can see themselves as other see them
- Applying problem-solving steps to realistic circumstances

- Creating concern over unsafe sexual behaviors and involvement in risky situations and risky partners
- Enhancing affective and cognitive awareness, expression, and control through exercises that cover topics such as:
  - HIV/STD terms, future dreams, self-defeating thoughts, condom misconceptions, how drugs/alcohol affect actions, weighing pros & cons, coping styles, problem analysis, sexual values, self-talk, and goal setting
- Teaching HIV/AIDS risk hierarchy and its application to oneself through exercises that include:
  - HIV/STD transmission, relative safety of different sex acts, familiarization with condoms, pros & cons of getting an HIV test, and consequences of behaviors and choices
- Using peer support to train in recognizing triggers for personal risk through activities such as:
  - exploring thoughts and feelings that lead to unsafe acts, recognizing those feelings, identifying circumstances that contribute to unsafe acts, analyzing problems, and encouraging participants to give feedback on role-plays, express appreciation, and give tokens
- Building skills in problem solving, personal assertiveness, and HIV/AIDS harm reduction with exercises such as:
  - setting your own sexual limits, putting condoms on penile and vaginal models, role-playing affects of drugs/alcohol, practicing problem-solving steps, getting back in control, trying relaxation techniques, assessing a partner's risk, using "I" statements in assertive communication, switching negative thoughts to positive ones, and dealing with rationalizations and slip-ups

Procedures describe the activities that make up the content of the intervention and provide direction to agencies or organizations regarding the conduct of the intervention. Procedures for implementing the eight sessions of Street Smart follow below:

Getting the Language of HIV and STDs: A basic assumption in this session is that knowing the facts about HIV/AIDS is essential, because this knowledge allows a person to protect himself/herself and others. Furthermore, understanding HIV/AIDS allows people to monitor their own effectiveness at implementing HIV intervention strategies. This session uses a knowledge game and role plays so participants will become familiar with the key components of the intervention (tokens, feeling thermometer) and receive basic information/understanding of HIV and other STIs, how they are transmitted, and their personal risk factors.

Personalized Risk: The main point of this session is to use role plays and group brainstorming to help participants figure out which of their behaviors put them at risk, and which triggers lead to unsafe behaviors. In this session, participants will increase familiarity with key components of intervention, understand safer sex, recognize personal risk behaviors, learn their triggers that increase their personal risk and learn to set personal limits

How to Use Condoms: Youth often feel anxiety about condom use. The main point of this session is for participants to be comfortable talking about and using condoms. Participants will

increase familiarity with key components of intervention, learn and practice the use of male and female condoms correctly and increase comfort level with condoms.

Drugs and Alcohol: The main point of this session is to use role plays and confronting beliefs so participants can identify how drugs and alcohol affect their thinking and choices. Participants will understand how alcohol and drugs affect the ability to practice safer sex, examine the pros and cons of substance use, learn how drugs and alcohol can affect a person, understand addiction and triggers for substance use, and learn skills to break the cycle of addiction.

Recognizing and Coping with Feelings: The main point of this session is to use role plays and the feeling thermometer so participants will be able to identify different coping styles in tough situations, and to problem solve solutions. Participants will learn skills to cope with stressful feelings, become familiar with the SMART method for coping/problem-solving and learn relaxation techniques

Negotiating Effectively: Participants will learn how to stand up for their own personal values and review key components. Participants will use interpersonal problem solving and role playing to explore personal sexual values, learn to deal with peer pressure, develop problem-solving skills, and learn to communicate effectively using "I" statements.

Self Talk: Participants engage in educational games and exercises to learn how to use their thoughts and self-talk to help them make safer decisions. Participants will review key components, learn how to think through positive and negative events to facilitate protective actions, learn to break the cycle of negative thoughts, practice thinking positive thoughts about self and learn helpful 'self-talk' to keep themselves safe.

Safer Sex: Participants engage in a small group discussion and create a media message (music video, soap opera, commercial) to figure out why they engage in risky behaviors and to learn how to argue against their rationalizations. Participants will review key components, figure out personal risk in unclear sexual situations, learn to combat rationalizations, strategize how to deal with slip-ups and apply what they have learned for the making of a video or soap opera.

RESOURCE REQUIREMENTS

Facilitators should have extensive experience working with youth and extensive knowledge of at-risk youth. The intervention is implemented by trained counselors. Facilitators should understand the underlying principles of the program, the theories behind the intervention and have knowledge of the way that youth operate. For example, facilitators need to know that few youth know how to apply safer sex practices, and that youth is a time of experimentation, and that having been sexually abused increases the risk of youths practicing unsafe sex. The Street Smart implementation manual has guidance on other things facilitators need to know. Facilitators need to be skilled in group dynamics, relating the intervention content to the lives of the youth, to reward frequently observable positive behavior, to be supportive, non-judgmental, give praise and build on strengths. Facilitators should be aware that some participating youth may already have been adversely affected by the HIV epidemic. The Street Smart implementation manual provides other tips for successful facilitation of the intervention.

The intervention requires a private room, a VCR, television and a video camera. Staff need to know how to operate the equipment and how to teach others to use it.

Community resources must be in place to facilitate the desired behavior—practicing safer sex. From research on teenage pregnancy and drug and smoking prevention, it is known that coordinating services for youth is critical. These youth often rely heavily on peers rather than adults for obtaining information and other forms of support partly because these other sources of support are unavailable to them.

The youth served in this training program need a variety of resources, including HIV counseling testing and referral, health care, alcohol and drug rehabilitation, legal aid, advice on how to take the GED exam, help in enrolling in athletic programs, and housing. To access these services, youth also need to become more self-directed, responsible consumers. To meet this objective, youth require more than just a discussion of where these services can be obtained: they need to be taken to community agencies and centers where they can personally meet the staff and become familiar with different sites and their services.

The stabilization and integration of community social services for youth may be the single best predictor of safer sex and drug use behavior. Therefore, it is essential that HIV/AIDS prevention programs establish strong working links between difference social service agencies at both the leadership and staff levels.

RECRUITMENT

Implementing Street Smart involves recruiting very high risk youth to participate in the intervention. Staff can identify participants and present the intervention as part of the runaway and homeless shelter's best practices that benefit clients. Incentives, when possible, can play a role in recruitment. General recruitment into the eight Street Smart sessions can include word of mouth, and other marketing strategies including flyers, newsletters, and special events. Peer-to-peer recruitment strategies can also be effective ways to bring clients into the agency, and to participate in the intervention. Please see the Procedural Guidance for Recruitment in this document for explanation of possible recruitment methods.

PHYSICAL SETTING CHARACTERISTICS

Ensuring the success of Street Smart begins even before the first session. When designing an HIV/STD prevention education program, it is important that participants have an inviting, comfortable, and safe environment. The following items need to be addressed:

- Attractive and easily understood promotional materials
- Adequate notice so prospective participants can arrange their schedules to fit the program
- A telephone number for questions regarding the program
- A private room

- A room large enough for the expected number of participants
- Comfortable temperature and fresh air
- Refreshments
- Sufficient materials for all participants, such as nametags, tissues, paper, pens/pencils, copies of the agenda
- Clear, correct, and understandable visual aids
- A suggestion/comment box to permit individuals to ask questions or give comments anonymously

NECESSARY POLICIES AND STANDARDS

Before an agency attempts to implement Street Smart, the following policies and procedures should be in place to protect participants, and the agency:

Informed Consent: Agencies must have a consent form which carefully and clearly explains in accessible language the agency's responsibility and the participants' rights. Individual state laws apply to consent procedures for minors, but at a minimum consent should be obtained from each participant and/or a legal guardian if the participant is a minor or unable to give legal consent. Client participation must always be voluntary and documentation of this informed consent must be maintained in the client's record.

Legal/Ethical Policies: Agencies must know their state laws regarding disclosure of HIV status to sexual and/or needle-sharing partners, and agencies are obligated to inform participants of the potential duty warn and the agency's responsibility if a client tests positive for HIV. Agencies also must inform participants about state laws regarding the reporting of domestic violence, child abuse, sexual abuse of minors, and elder abuse.

Confidentiality: A system must be in place to ensure that confidentiality is maintained for all participants in the program. Before sharing any information with another agency to which a client is referred, signed informed consent from a client or his/her legal guardian must be obtained.

Data Security: Collect and report data consistent with CDC requirements to ensure data security and client confidentiality.

Cultural Competence: Agencies must strive to offer culturally competent service by being aware of the demographic, cultural, and epidemiological profile of their communities. Agencies should hire, promote, and train staff across all disciplines to be representative of and sensitive to these cultures. In addition, materials and services must be offered in the preferred language of clients/consumers where possible, or translation should be available if appropriate. Finally, agencies should facilitate community and client/consumer involvement in designing and implementing prevention services to ensure that important cultural issues are incorporated. The Office of Minority Health of the Department of Health and Human Services has published the *National Standards for Culturally and Linguistically Appropriate Services in Health Care* which should be used as a guide for ensuring cultural competency in programs and services. Please see

the Cultural Competence section in the introduction of this document (page 9) for standards for developing culturally and linguistically competent programs and services.

Referrals: Agencies must be prepared to supply appropriate referrals to session participants as necessary. Providers must know about referral sources for prevention interventions/counseling (Partner Counseling and Referral Services, or other Health Department/Community Based Organization prevention programs) if clients need additional assistance in decreasing risk behavior.

Volunteers: If the agency is using volunteers to assist in or conduct this intervention, then the agency should know and disclose how their liability insurance and worker's compensation applies to volunteers. Agencies must ensure that volunteers also receive the same training and are held to the same performance standards as employees. Agencies must also ensure that volunteers sign and adhere to a confidentiality statement. All training should be documented.

QUALITY ASSURANCE

A strong component of quality assurance is preparing a plan to implement Street Smart. Developing a comprehensive implementation plan will facilitate understanding and "buy-in" from key stakeholders and increase the likelihood the intervention runs smoothly.

Quality assurance on this intervention also requires there is someone at the agency that will provide hands-on leadership and guidance for the intervention—from preparation through institutionalization. In addition, a decision maker is needed in the agency who will provide higher-level support, including securing resources and advocating for Street Smart, from preparation to institutionalization.

The protocol used when linking youth and escorting youth to community resources also involves a measure of quality assurance in that consumers from the community resource can be paired with youth when touring the resource and its services. Ensure that community resource staff follow-up and invite youth back and provide feedback to your sponsoring program on those visits.

Throughout implementation, it is necessary to determine whether staff is delivering Street Smart with fidelity to the four core elements. A fidelity checklist is available in the intervention kit and can be used by the agency as a quality assurance tool for this purpose. It is also necessary to identify and address any issues to assure the intervention is meeting the needs of agency clients and staff.

MONITORING AND EVALUATION

Evaluation and monitoring intervention activities include the following:

- Collect and report standardized process and outcome monitoring data consistent with CDC requirements;

- Enter and transmit data for CDC-funded services on PEMS (Program Evaluation Monitoring System), a CDC-provided browser-based system, or describe plans to make a local system compatible with CDC's requirements;
- Collect and report data consistent with the CDC requirements to ensure data quality and security and client confidentiality;
- Collaborate with CDC in assessing the impact of HIV prevention activities by participating in special projects upon request.
- Collect and report data on the following indicators:
    - **I.C-** Proportion of persons that completed the intended number of sessions for each of the following interventions: individual level interventions (ILI) and group level interventions (GLI).
    - **III.B-** Proportion of persons at very high risk for HIV infection that completed the intended number of sessions for each of the prevention interventions supported by this program announcement.
    - **IV.A-** Proportion of client records with the CDC-required demographic and behavioral risk information

KEY ARTICLES AND RESOURCES

[1] Rotheram-Borus M.J, Van Rossem R, Gwadz M, Koopman C, Lee M. (1997). Reductions in HIV risk among runaway youths.Los Angeles, CA: University of California, Department of Psychiatry, Division of Social and Community Psychiatry.

[2] Rotheram-Borus M.J, Koopman C, Haignere C, Davies M. (1991). Reducing HIV sexual risk behaviors among runaway adolescents. Journal of the American Medical Association 266(9), 1237-1241.

Kelly JA, Heckman TG, Stevenson LY, et al. (2000). Transfer of Research-Based HIV Prevention Interventions to Community Service Providers: Fidelity and Adaptation. In AIDS Education and Prevention, 12, Supplement A, 87-98. The Guilford Press.

Moon MW, McFarland W, Kellogg T, Baxter M, Katz M, MacKellar D, Valleroy L. (2000). HIV risk behavior of runaway youth in San Francisco: Age of Onset and Relation to Sexual Orientation. Youth and Society, Vol. 32, No. 2, December. Sage Publications, Inc.

Rotheram-Borus M.J, Noelle, L. (2000). Training facilitators to deliver HIV manual-based interventions to families. In Working with families in the era of HIV/AIDS. Pequegnat W, Szapocznik J. (eds.). Sage: New York.

For more information on the Street Smart intervention, training and technical assistance, or to get your name on a list for a future training, please go to the website: www.effectiveinterventions.org.

PROCEDURAL GUIDANCE FOR IMPLEMENTATION OF MANY MEN, MANY VOICES

CBO PROGRAM ANNOUNCEMENT RFP 04064
DEPARTMENT OF HEALTH AND HUMAN SERVICES

DESCRIPTION OF MANY MEN, MANY VOICES

Many Men, Many Voices (MMMV) is a six- or seven-session, group level HIV/STD prevention intervention for gay and bisexual men of color adapted from the Behavioral Self-Management and Assertion Skills intervention[1] (now called Partners in Prevention) developed by the Center for AIDS Intervention Research (CAIR) in the Department of Psychiatry and Behavioral Medicine at the Medical College of Wisconsin. This intervention has been packaged by CDC's Diffusion of Effective Behavioral Interventions (DEBI) project and information on obtaining the intervention training and materials is available at www.effectiveinterventions.org.

The original model intervention was condensed from twelve sessions to six (with an optional seventh) but individual sessions were expanded from 90 minutes to 2-3 hours. It was adapted and tailored using the strategies outlined in the *Procedural Guidance,* to address behavioral influencing factors specific to gay men of color including cultural/social norms, and values and sexual relationship dynamics. The adaptation, tailoring and implementation of this intervention were done in partnership with Men of Color Health Awareness (MOCHA), People of Color in Crisis (POCC) and the Center for Health and Behavioral Training (CHBT).

Many Men Many Voices is designed to be facilitated by a peer in groups of 6-12 participants. The three hour sessions aim to foster positive self identity, educate participants about their HIV/AIDS risk and teach assertiveness skills. For participants who are unaware of their HIV status, the benefits of knowledge of serostatus should be addressed, and referral for counseling and testing should be provided when appropriate. The program utilizes behavioral skills practice, group discussions, role play and lectures in highly interactive sessions.

In the original Partners in Prevention intervention, gay men who participated reduced their frequency of unprotected anal intercourse and increased their use of condoms significantly more than men in the control condition.

CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES

Core Elements are those components that are critical features of an intervention's or strategy's intent and design and that are thought to be responsible for its effectiveness. Consequently, they must be maintained without alteration to ensure program effectiveness. Core elements are

derived from the behavioral theory upon which the intervention or strategy is based. They are essential to the implementation of the program and cannot be ignored, added to, or changed. There are 5 core elements of MMMV:

1) Educate clients about HIV risk and sensitize to personal risk.

2) Develop risk reduction strategies.

3) Train in behavioral skills.

4) Train in sexual assertiveness.

5) Provide social support and relapse prevention.

Key Characteristics are crucial activities and delivery methods for conducting an intervention, which may be tailored for different agencies and at-risk populations to meet the needs of the target population and ensure cultural appropriateness of the strategy. MMMV has the following key characteristics:

- Foster positive identity development for gay men of color by exploring the dual identity culture of gay men of color, addressing social and cultural norms within racial/ethnic communities, exploring positive and negative peer influences, setting self-standards and clarifying values
- Discuss sexual roles and risks, addressing knowledge of HIV transmission risk and exploring beliefs about those risks
- Address perceived personal risk and personal susceptibility for HIV infection as well as the perceived benefits and outcomes of remaining HIV negative
- Increase skills and self-efficacy for protective behaviors and intentions to engage in those behaviors
- Explore sexual relationship dynamics including power dynamics
- Address the importance of peer support and social influence on maintaining healthy behaviors

Procedures describe the activities that make up the content of the intervention and provide direction to agencies or organizations regarding the implementation of the intervention. Procedures for implementing MMMV follow.

Many Men, Many Voices is implemented by one or two group level facilitators who are trained in the specific content of each group session. The facilitators are responsible for coordinating all activities and organizing all aspects of the intervention. At least one of the facilitators must be a gay or bisexual male of color.

The intervention consists of educational materials for distribution which may be used to recruit persons at risk into the group. Outreach by project staff is also necessary to recruit gay/bisexual men of color into the intervention sessions. The intervention was not designed for heterosexual males and they should not be included in the sessions. Men of color who have sex with other

men but do not identify as "gay" or "bisexual" are appropriate for the intervention as long as they are willing to discuss the STD and HIV risks of male to male sexual behaviors and the risk reduction methods that constitute safer sex.

The original 12 session intervention[1] was tailored and condensed into the 6 sessions of Many Men, Many Voices. An optional seventh session may be added at the discretion of the group facilitators. The seven sessions address specific influencing factors in a purposeful sequence including:

Session 1: The Dual Identity Culture of Gay Men of Color
Session 2: HIV Prevention for Gay Men of Color – Sexual Roles and Risks
Session 3: HIV Risk Assessment and Prevention Options
Session 4: Intentions to Act and Capacity to Change
Session 5: Partner Selection, Communication and Negotiation
Session 6: Social Support and Problem Solving to Maintain Change
Session 7 (optional): Building a Healthy Community

The original 75-90 minute sessions were tailored and expanded to 2-3 hour Many Men, Many Voices sessions. Sessions contain very little presentation of information, and instead are highly interactive and allow for the clients to gain knowledge experientially (for example, through the use of educational games, and other exercises). Through their formative evaluation, the agencies that adapted the intervention found that the African American gay/bisexual men that they served were more inclined to attend 7 sessions of 2-3 hours each rather than 12 sessions of 75-90 minutes. An agency may conduct its own formative evaluation to determine whether participation rates would increase or decrease relative to the number of sessions and the length of each session. Whether the agency chooses to conduct fewer sessions of longer length or to conduct more sessions of shorter length should be based on client needs and client convenience. The intervention may also be condensed into a weekend retreat format, covering the 18-21 hours of intervention materials over the course of a single weekend. The entire content of the sessions constitutes the core elements of this intervention and so the entire content must be covered to implement the intervention with fidelity.

RESOURCE REQUIREMENTS

The agency should hire at least one full-time group facilitator. A second facilitator can be hired at a full- or part-time level depending on the level of need in the community. Group facilitation skills are necessary and should be a consideration in hiring staff or in initial training of staff. Facilitators are responsible for all aspects of the program including recruitment, group facilitation, record keeping, quality assurance, and monitoring and evaluation. Therefore it is recommended that each group facilitator run no more than two concurrent groups. An administrative employee of the community based organization typically supervises the group facilitator(s).

In addition to staff of the intervention, materials that are needed to conduct the intervention include markers, easel charts and newsprint, a VCR and television, an overhead projector, masking tape, poster boards, and clothespins.

RECRUITMENT

The target population for Many Men Many Voices is gay and bisexual men of color. Recruitment into the intervention sessions will include outreach to venues where MSM of color can be reached. Printed materials may also be used to recruit MSM of color into the intervention. The group facilitators generally recruit participants, but clients may also be referred to the groups through other programs. It is best if the group facilitators interview potential group members prior to the first group to determine if the individual is appropriate for the group.

Agencies wishing to implement Many Men, Many Voices should review the Procedural Guidance for Recruitment in order to choose a recruitment strategy that will work in the setting in which they plan to implement MMMV.

PHYSICAL SETTING CHARACTERISTICS

Agencies implementing Many Men Many Voices should choose a location that is easily accessible from public transportation routes and is also in communities where young gay/bisexual men of color live, work and socialize. The groups are usually held at the CBO, but can be held in other locations. Ideally the space should have comfortable seating for discussions. The intervention sessions must be conducted in a private and secure location so that confidentiality of participants can be maintained. It is crucial that intervention sessions are not interrupted by distractions such as people entering and exiting the room, or outside noise levels.

NECESSARY POLICIES AND STANDARDS

Before an agency attempts to implement MMMV the following policies and procedures should be in place to protect participants, the agency, and the MMMV program team:

Targeting of Services: Agencies must establish criteria for, and justify the selection of, the target populations. Selection of target populations must be based on epidemiological data, behavioral and clinical surveillance, and the state or local HIV prevention plan created with input from the state or local community planning group(s).

Informed Consent: Agencies must have a consent form which carefully and clearly explains in accessible language the agency's responsibility and the participants' rights. Individual state laws apply to consent procedures for minors, but at a minimum consent should be obtained from each participant and/or a legal guardian if the participant is a minor or unable to give legal consent. Client participation must always be voluntary and documentation of this informed consent must be maintained in the client's record.

Safety: Agency policies must exist for maintaining safety of workers and clients. Plans for dealing with medical or psychological emergencies must be documented.

Confidentiality: A system must be in place to ensure that confidentiality is maintained for all participants in the program. Before sharing any information with another agency to which a client is referred, signed informed consent from a client or his/her legal guardian must be obtained.

Legal/Ethical Policies: Agencies must know their state laws regarding disclosure of HIV status to sexual and/or needle-sharing partners, and agencies are obligated to inform participants of the potential duty warn and the agency's responsibility if a client tests positive for HIV. Agencies also must inform participants about state laws regarding the reporting of domestic violence, child abuse, sexual abuse of minors, and elder abuse.

Linkage of Services: Recruitment and health education and risk reduction must be linked to counseling, testing, and referral services for clients of unknown status, and to care and prevention services for people living with HIV (PLWH). Agencies must develop ways to assess whether and how frequently the referrals made by staff were completed.

Referrals: Agencies must be prepared to supply appropriate referrals to session participants as necessary. Providers must know about referral sources for prevention interventions/counseling (Partner Counseling and Referral Services, or other Health Department/Community Based Organization prevention programs) if clients need additional assistance in decreasing risk behavior.

Data Security: Collect and report data consistent with CDC requirements to ensure data security and client confidentiality.

Cultural Competence: Agencies must strive to offer culturally competent service by being aware of the demographic, cultural, and epidemiological profile of their communities. Agencies should hire, promote, and train staff across all disciplines to be representative of and sensitive to these cultures. In addition, materials and services must be offered in the preferred language of clients/consumers where possible, or translation should be available if appropriate. Agencies should facilitate community and client/consumer involvement in designing and implementing prevention services to ensure that important cultural issues are incorporated. The Office of Minority Health of the Department of Health and Human Services has published the *National Standards for Culturally and Linguistically Appropriate Services in Health Care* which should be used as a guide for ensuring cultural competency in programs and services. Please see the Cultural Competence section in the introduction of this document (page 9) for standards for developing culturally and linguistically competent programs and services.

Personnel Policies: Agencies conducting recruitment, outreach, and health education and risk reduction, must established a code of conduct. This code should include, but not be limited to, no drug or alcohol use, appropriate behavior with clients, and no loaning or borrowing of money.

Volunteers: If the agency is using volunteers to assist in or conduct this intervention, then the agency should know and disclose how their liability insurance and worker's compensation applies to volunteers. Agencies must ensure that volunteers also receive the same training and

are held to the same performance standards as employees. Agencies must also ensure that volunteers sign and adhere to a confidentiality statement. All training should be documented.

QUALITY ASSURANCE

Quality assurance (QA) activities for both facilitators and participants should be in place when implementing MMMV:

Facilitator: Training for facilitators should address the following three areas: (1) completion of a training workshop, including review of the intervention theory and materials; (2) participation in practice sessions; and (3) observed co-facilitation of groups, including practice of mock intervention sessions. Agencies should have in place a mechanism to ensure that all session protocols are followed as written. QA activities can include observation and review of sessions by key staff and supervisors involved with the activity. This review should focus on adherence to session content, use of interactive techniques; accessibility and responsiveness to expressed participant needs; and important process elements (e.g., time allocation, clarity of presentation). Selected intervention record reviews should focus on assuring that consent forms (signed either by the participant if he/she is over 18 or emancipated, or by a legal guardian) are included for all participants, and session notes are of sufficient detail to ensure that clients are participating actively.

Participant: Participants' satisfaction with the intervention and their comfort should be assessed at the final session of each module. Process monitoring systems should also track the number of sessions each participant attends, as well as reasons for non-attendance.

MONITORING AND EVALUATION

Evaluation and monitoring intervention activities include the following:

- Collect and report standardized process and outcome monitoring data consistent with CDC requirements;
- Enter and transmit data for CDC-funded services on PEMS (Program Evaluation Monitoring System), a CDC-provided browser-based system, or describe plans to make a local system compatible with CDC's requirements;
- Collect and report data consistent with the CDC requirements to ensure data quality and security and client confidentiality;
- Collaborate with CDC in assessing the impact of HIV prevention activities by participating in special projects upon request.
- Collect and report data on the following indicators:
    - **I.A-** The mean number of outreach contacts required to get one person with unknown or negative serostatus to access counseling and testing.
    - **I.B-** The proportion of person who access counseling and testing from each of the following interventions: individual level interventions and group level interventions.

- **I.C-** Proportion of persons that completed the intended number of sessions for each of the following interventions: individual level interventions (ILI) and group level interventions (GLI).
- **III.B-** Proportion of persons at very high risk for HIV infection that completed the intended number of sessions for each of the prevention interventions supported by this program announcement.
- **IV.A-** Proportion of client records with the CDC-required demographic and behavioral risk information.
- **V.A -** The mean number of outreach contacts required to get a person (living with HIV, their sex partners and injection drug-using contacts or at very high risk for HIV infection) to access referrals made under this program announcement.

KEY ARTICLES AND RESOURCES

[1]Kelly JA, St. Lawrence JS, Hood HV, Brasfield TL. (1989). Behavioral intervention to reduce AIDS risk activities. Journal of Consulting and Clinical Psychology, 57(1), pp. 60-67.